

ALJ will be set in accordance with § 405.1020.

(c) *Parties to a hearing.* The parties to a hearing are the parties to the reconsideration, the MA organization, and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ.

(d) *Insufficient amount in controversy.*

(1) If a request for a hearing clearly shows that the amount in controversy is less than that required under § 422.600, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than the amount required under § 422.600, the ALJ discontinues the hearing and does not rule on the substantive issues raised in the appeal.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4740, Jan. 28, 2005]

#### § 422.608 Medicare Appeals Council (MAC) review.

Any party to the hearing, including the MA organization, who is dissatisfied with the ALJ hearing decision, may request that the MAC review the ALJ's decision or dismissal. The regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate.

[70 FR 4740, Jan. 28, 2005]

#### § 422.612 Judicial review.

(a) *Review of ALJ's decision.* Any party, including the MA organization, may request judicial review (upon notifying the other parties) of an ALJ's decision if—

(1) The Board denied the party's request for review; and

(2) The amount in controversy meets the threshold requirement established annually by the Secretary.

(b) *Review of MAC decision.* Any party, including the MA organization, may request judicial review (upon notifying the other parties) of the MAC decision if it is the final decision of CMS and the amount in controversy meets the threshold established in paragraph (a)(2) of this section.

(c) *How to request judicial review.* In order to request judicial review, a

party must file a civil action in a district court of the United States in accordance with section 205(g) of the Act. See part 405 of this chapter for a description of the procedures to follow in requesting judicial review.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 65 FR 40331, June 29, 2000; 70 FR 4740, Jan. 28, 2005]

#### § 422.616 Reopening and revising determinations and decisions.

(a) An organization or reconsidered determination made by an MA organization, a reconsidered determination made by the independent entity described in § 422.592, or the decision of an ALJ or the MAC that is otherwise final and binding may be reopened and revised by the entity that made the determination or decision, under the rules in part 405 of this chapter.

(b) Reopening may be at the instigation of any party.

(c) The filing of a request for reopening does not relieve the MA organization of its obligation to make payment or provide services as specified in § 422.618.

(d) Once an entity issues a revised determination or decision, any party may file an appeal.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 70 FR 4740, Jan. 28, 2005]

#### § 422.618 How an MA organization must effectuate standard reconsidered determinations or decisions.

(a) *Reversals by the MA organization—*

(1) *Requests for service.* If, on reconsideration of a request for service, the MA organization completely reverses its organization determination, the organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(a)(1)).

(2) *Requests for payment.* If, on reconsideration of a request for payment, the MA organization completely reverses its organization determination, the organization must pay for the service no later than 60 calendar days after

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the date the MA organization receives the request for reconsideration.

(b) *Reversals by the independent outside entity*—(1) *Requests for service*. If, on reconsideration of a request for service, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Requests for payment*. If, on reconsideration of a request for payment, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the MA organization or the independent outside entity*—(1) *General rule*. If the independent outside entity's determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the MA organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision or that it has appealed the decision.

(2) *Effectuation exception when the MA organization files an appeal with the Medicare Appeals Council*. If the MA organization requests Medicare Appeals Council (the Board) review consistent with § 422.608, the MA organization may await the outcome of the review before it pays for, authorizes, or provides the service under dispute. A MA organization that files an appeal with the Board must concurrently send a copy of its appeal request and any accompanying

documents to the enrollee and must notify the independent outside entity that it has requested an appeal.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40331, June 29, 2000; 68 FR 50858, Aug. 22, 2003]

### **§ 422.619 How an MA organization must effectuate expedited reconsidered determinations.**

(a) *Reversals by the MA organization*. If on reconsideration of an expedited request for service, the MA organization completely reverses its organization determination, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(d)(2)).

(b) *Reversals by the independent outside entity*. If the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the MA organization or the independent outside entity*—(1) *General rule*. If the independent outside entity's expedited determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Effectuation exception when the MA organization files an appeal with the Medicare Appeals Council*. If the MA organization requests Medicare Appeals Council (the Board) review consistent with § 422.608, the MA organization may await the outcome of the review before it authorizes or provides the service